

Statement of Claimant or Other Person
(Form 234, Instructions)

Purpose: To notify Medicaid of important information relating to the claimant.

Distribution: Original – Case file

Instructions:

1. Name of Claimant
2. Medicaid Number of claimant
3. Name of Person making statement
4. Relationship to Claimant
5. Statement
6. Signature of Person making statement
7. Date of statement
8. Telephone Number
9. Mailing Address
10. Signature of Witness #1
11. Signature of Witness #2
12. Address of Witness #1
13. Address of Witness #2

STATEMENT OF CLAIMANT OR OTHER PERSON

Name of Claimant	Medicaid Number
(1)	(2)
Name of Person Making Statement (if other than above claimant)	Relationship to Claimant
(3)	(4)

Understanding that this statement is for a right to payment of Medicaid benefits by Alabama Medicaid Agency, I hereby certify that:

(5)

SIGN ON BACK

I understand that anyone who knowingly makes a false statement or misrepresents material facts in an application to determine eligibility for Medicaid may be committing a crime punishable under Federal or State law, or both. I affirm that all information I have given in this document, or in support of it, is true.

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In signing this statement, I affirm that all information I have given in this document is true.

SIGNATURE OF PERSON MAKING STATEMENT

Signature (First name, middle initial, last name) (Write in ink)

S I G N

(7)
Date (Month, day, year)

H E R E _____
(6)

(8)
Telephone Number

=====

Mailing Address (Number and Street, Apt. No., P.O. Box, Rural Route)

(9)

City and State

Zip Code

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

(10) _____
(11)

Address (Number and Street, City, State, and Zip Code) | Address (Number and Street, City, State, and Zip Code)

(12) _____
(13)